INTERNATIONAL AND REGIONAL INFLUENCES ON TONGA'S MENTAL HEALTH ACT

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Abstract

In 2001 Tonga adopted a new mental health law as part of an overall health sector reform process. This was only the third iteration of a statute designed to address the island Kingdom's mental health sector since 1948. International actors had considerable influence over the form and substance of each of these law changes with only minimal input from the indigenous mental health sector. Moreover, this article will situate the 2001 Act as falling short of international best practice at the time of adoption. The circumstances of how these laws came to be adopted in Tonga play an important role in understanding the law's proper context within national medico-legal institutions. Given the long gaps in time between policy change at the statutory level, this article will then argue that practitioner application and court interpretation of Tonga's constitutional rights will likely be the source of any broadening of protections for individuals with mental illness in the near term. Two recent decisions that have implicated Tonga's Mental Health Act will be discussed. These cases each raise natural justice concerns within the mental health context. This article will conclude that because the law was largely the product of international intervention and was not guided by the development of a local mental health policy setting forth the indigenous aspirations or guiding principles of the mental health system in Tonga, future reforms should follow such a formula and in the interim, advocates should appeal to natural justice to secure their client's rights are protected in the area of mental health court practice.

I. Introduction

In 2001, Tonga became one of the first of many Pacific Island countries to reform its mental health legal framework when it adopted its Mental Health Act (MHA 2001). The adoption of this law reform, however, did not happen on its own. Along with the MHA 2001, Tonga's parliament passed laws

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revamping most of its health sector legislative regime.[1] This article sets out to consider this process of law change in the Tongan context. In particular, this article shall examine the 2001 statutory change brought about with international assistance in Tonga's mental health policy and law history. After presenting Tonga's mental health policy context it shall then consider the composition of the current mental health system in Tonga. This article will argue that indigenous involvement in the mental health law reform was minimal with important implications for the resulting law. It will show that the adopted law mirrors Australian mental health law in several important aspects, and neither international best practice at the time of adoption nor Tonga's indigenous mental health policy context. Moreover, the law has serious deficiencies as a tool for securing individual rights in the mental health setting or for institutionalizing some of Tonga's important functional indigenous mental health practices. The consequences of this mismatch have important implications for litigants including providing possibly inadequate protection of individual liberty interests. The article concludes that since statutory changes in Tonga's mental health policy area tend to be infrequent, the best tool for advocates of individuals with mental illness is likely to be found in an appeal to natural justice principles. Two recent cases interpreting the MHA 2001 will be considered as embodying this reasoning.

The article is presented in four main parts. First, the article will consider an overview of Tonga's mental health law context. Here, the current understandings and role of mental health in Tonga will be discussed. The historical development of the government's role in mental health is presented. The evidence is drawn from both textual sources and interviews conducted with Tongan government and civil society representatives. Following this discussion, a brief overview of the international mental health as human right context is given. This article argues that since the reform efforts in Tonga's health sector were ostensibly international efforts and not essentially bilateral efforts between Australia and Tonga or purely domestic policy responses to a perceived problem of national importance, consideration of the international context is critical to understanding the environment within which important international and regional organizations approach mental health law reforms in such contexts. This section presents the mental health context as one framed by human rights as advanced through disability human rights in international instruments.

The article also incorporates the role international and regional entities played in the health sector reform process generally and mental health law reform in particular. The key actors identified in this section include the Australian government (acting then through AusAID), the Asian Development Bank and the World Health Organization, including a regional organization called the Pacific Island Mental Health Network (PIMHnet).

1 These new laws included: Therapeutic Goods Act [2001], Nurses Act [2001], Medical and Dental Practitioners Act [2001], Pharmacy Act [2001] and a Health Practitioners Review Act [2001].

The role each played in crafting Tonga's current Mental Health Act is considered. The article concludes with a discussion of Tonga's current mental health law and natural justice jurisprudence. It argues that while few court findings have addressed mental health issues, these cases failed to address how Tonga's long-standing natural justice principles might be implicated to address potential questionable detentions under MHA 2001.

II. Tonga's Mental Health Law Context

Central to any effective law is perhaps its quality as reflective of community values in terms of both fit and purpose. Mental health law is intrinsically linked to community standards of "normalcy" and should bear some close nexus to community standards concerning defining and responding to abnormality. As one high-ranking government official, a member of the Mental Health Advisory Committee established under the MHA 2001 discussed mental health in Tonga as being:[2]

> … dealt with initially, of course, at home in the community, so it is normally the parents, grandparents, aunties and uncles or siblings. And as per normal, small communities tend to stigmatize mentally disabled, and so carers often marginalize them.

After the home and community attempts, the next step for individuals with a mental illness in Tonga is within Tonga's mental health system, which essentially orbits around the nation's sole psychiatrist, a Tongan, Dr Mapa Puloka. Dr Puloka oversees the national mental health unit and small staff located at the nation's main hospital in Nuku'alofa. As in other jurisdictions, other common state actors often implicated in mental health symptom management include the prosecutors, courts and prison system.

Tonga's government-sponsored health system ostensibly began with the erection of Tonga's first hospitals in the major island groups in 1909.[3] The government ministry dedicated to health would however not emerge until a decade later following the Spanish Influenza pandemic of 1918.[4] The general wards of Tonga's Vaiola Hospital would serve as a primary point of official contact for less acute mental health concerns until 1977, when the establishment of the country's first psychiatric unit occurred.[5]

In more recent time a vibrant NGO sector has emerged that has increasingly taken on a service delivery and policy advocacy role. One main

2 Interview with the author, February 2011.

3 IC Campbell "A Historical Perspective on Aid & Dependency: The Example of Tonga" (1992) Pacific Studies 15(3) at 118.

4 M Poltorak "Aspersions of agency ghosts, love & sickness in Tonga" (PhD Thesis, University College London, 2002) at 207.

5 At 207.

concern identified by these organisations was the still foreign nature of seeking counselling from secular counsellors outside of church and family. As one prominent NGO representative commented:[6]

> Counselling is a very new, Western concept to many Tongans. We've had to do a lot of awareness to encourage women to come in and talk to complete strangers about what is going on at home … so talking about mental health again, postnatal depression, Tongans believe this is a *Palagi* thing, how can you get depressed after having a baby unless you have *'aitu* or mentally ill. Nothing about why is she depressed? What are the contributing factors to this? It is very myth based.

At the same time, NGOs tended not to view their role optimistically, at least in terms of service provision. One respondent lamented:[7]

> Well, there is actually no service provider that states that they provide mental health counselling or services. For example, the services that we provide, we like to think makes some contribution to that to help women with depression at home due to physical or mental abuse or financial stresses … but there is no provider providing specific care.

In addition, NGOs noted the relatively minor importance given to mental health issues by the budgetary process. One respondent stated that:[8]

> I know for a fact that mental health and even the psychiatric ward received the lowest portion of the health budget in past years as it just wasn't prioritized. Non-communicable diseases has been prioritized …

Yet, while the area has seemingly been low priority for the government, it has nonetheless continued to evolve along with Tonga's health system and its related legal frameworks.

These home-grown NGOs have engaged in attempts to shift these domestic health policy preferences. One of the more interesting recent developments in Tonga's NGO sector has been the establishment of the Tonga Mental Health and Disabilities Association in September 2010.The organization emerged after a decade of advocacy for such a group by Dr Puloka. One of the organization's founders observed that the membership consists primarily of family members of those with mental illness but lacking in knowledge about the nature of the illnesses, prognosis and treatment.[9] The initial efforts are to

6 Interview with the author, February 2011.
7 Interview with the author, February 2011.
8 Interview with the author, February 2011.
9 Interview with the author, February 2011.

get the group established locally and there were no significant external links at the time of interview. The organization was planning to start with some fundamental functions such as organizing care for individuals in the mental health unit by providing supplemental food and clothing to the patients. They are preoccupied with "the basics at this point before thinking about policy".[10] Despite the lack of policy focus at this point in time, circumstances seem to warrant attention. As this respondent said:[11]

> … when we went in as an association and viewed the conditions at the hospital we were very concerned. It is designed for 20 patients but is currently holding 57 and some of the male patients are sleeping outside. So I think it is important that they fill positions provided for under the Act.

The explanation for the state of matters within the mental health system is linked to the nation's politics. The lack of individual advocacy in Tonga was cited as being a possible contributing factor for this and was linked to a culture within which:[12]

> … doctors are highly regarded. We always look to them as being helpers so I think Tongan's are very reluctant to question why something has happened … Tongans are very reluctant to take [an issue] to court [because] the professionals they see as very important. I think it is also institutional, we don't have clear guidelines in the legislation or in the procedure about how we can complain. Most people think they only way they could complain is to the Minister and this is seen as too much to do.

Tonga's civil society stakeholders tend to view the political reforms positively in the hopes of establishing a clear policy serving to guide the Ministry of Health and to provide information to the public, as well as provide clearer guidance for lodging complaints.

Yet, for most Tongan civil society organizations mental health was a tangential concern that was relevant to their primary responsibilities. These core responsibilities include domestic violence, drug abuse, or the concerns about deportees in Tonga. One domestic violence NGO representative opined that:[13]

> I think mental health plays a huge role in domestic violence … [m]ental health pays a role in how you cope with these daily stresses and if you don't have the

10 Interview with the author, February 2011.
11 Interview with the author, February 2011.
12 Interview with the author, February 2011.
13 Interview with the author, February 2011.

> support base in the people around you it can lead on to something more serious, more damaging, it can lead to mental illness so mental health is very important.

This understanding was reflected in a comprehensive strategy to approach policy development in key areas to the organization. The domestic violence advocacy organization consulted in this study saw its role in the policymaking process as showing:[14]

> … why it is important that we promote and put our resources in to push the mental health issue forward because it can have such a damaging affect on women and children survivors. For instance our incest survivor cases, these are girls who have gone through years of sexual abuse. Helping them maintain their mental health helping them cope is so critical, the last thing we want to see is them having temporary or permanent mental illness … give case studies and talk about client stories, highlight the loop holes and the gaps where services are not available, you know, probably contribute to the myths that we continue to hear that maybe she is losing her nutters as she's just walked out of the house, she's shut her bedroom door and shut everyone out, you know, those little scenarios that have built up a lot of myths in our society, and then traditional healers are called to shake her out of her mindset.

NGOs, such as this domestic violence entity, had been inextricably linked to foreign aid and development policies and have had to adjust to changing times. This particular NGO existed at one time as part of the government, and while it provided consistent and regular funding and a guaranteed job for its employees, it had limited its advocacy activities due to its place as part of the apparatus of government.

Other concerns, such as suicide prevention entities, were also closely allied with other mental health civil society organizations. Tonga Lifeline is the most prominent of these and is under the direction of a local pastor who has worked for many years on these matters. He felt that the central role played by churches in service delivery to be:[15]

> … an element of pastoral care on the level of caring because everyone in the community or in the villages or islands here in Tonga is having a church and the church is belonging, under the umbrella of religious leaders and our traditional counsellors here in Tonga are the Ministers, Pastors of the

14 Interview with the author, February 2011.
15 Interview with the author, February 2011.

> local churches, what we are trying with Dr Puloka is just to equip them with some technical skills on the basic levels just to know the first stages of the mental health problems.

While he had been working on these concerns for many years and Lifeline itself had been setup in Tonga in 1981, it was a 2005 regional meeting called by WHO that led to data tracking there. The 2005 meeting and the international attention it generated, moved the issue of suicide from purely a church-recognized issue in Tonga to the government agenda. He noted that the hotline received between 40-80 calls a month and nearly the same number of walk-ins.

The legal framework within which these developments have taken place dates only to the mid-twentieth century but has evolved rapidly in recent years. Tonga's legislative history on mental health began with the Lunatics Detention Act of 1948 (No. 9) which defined a "lunatic" as an "idiot and any other person of unsound mind" but defined neither of these terms in the law. This law appears to have been based on a Fijian Lunatic's Act of the era, itself based upon British mental health law. In essence, the Act permitted the detention of one deemed a "lunatic" in any "place of detention", defined as "any house or building", as designated by the Privy Council. There was no requirement that this be either the prison or hospital, though the prison became designated as the nation's asylum.

This law persisted until 1992, when the Mental Health Act of that year repealed the singular "lunatic" designation with three terms: "mental disorder", which was understood as "mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of the mind"; "mental handicap", defined as "a state of arrested or incomplete development of mind which can render a person incapable of independent living"; and "mental illness", defined as a "psychiatric disorder which substantially disturbs a person's thinking, feeling, or behaviour and impairs the person's ability to function".[16] In addition, the Act introduced the notions of "alcoholic" and "drug addict" as included dependents on these substances. The Act was a curiosity in the sense that, as reflected in this research as well as Poltorak's[17], both lawyers and medical personnel found the Act utterly unworkable and the degree of consultation between these professionals and the law's drafters seems limited.

By 2000, an opportunity for law reform arose with the health sector reform program initiated in partnership with AusAID and the presence of an Australian legal consultant with experience on such matters. Records of the Parliamentary consideration of Tonga's Mental Health Act 2001 contain

16 Mental Health Act [MHA] 1992, s. 2.
17 Poltorak, above n 4 at 207.

only a very limited, but revealing, discussion of the proposal.[18] The Minister of Health was present to address questions and Dr Puloka reported being on-hand, outside of the chamber, in case he was needed to address any specific points raised by the members; he was not called. The Minister of Health presented the law as necessary to permit voluntary treatment of individuals since all previous laws only envisioned involuntary, custodial treatment.

An issue was raised by Samiu Vaipulu, Tonga's Deputy Prime Minister at the time of writing, regarding a "doctor working in this area", who must be assumed to be Dr Puloka since there were no other doctors working in mental health at this time. Vaipulu said that this doctor was alleged to inappropriately use his authority by threatening to detain people with whom he is unhappy under the guise of a mental disturbance.[19] The Minister of Health responded that one of the purposes of the new law is to more actively bring the judiciary into the involuntary commitment process to ensure effective review of medical determinations in this regard. Consensus was soon reached, however, around the notion that in emergency situations, those in which there is a public behaviour that might cause harm to members of the public, the doctor should retain (as he does under the 2001 Act) the authority to immediately detain an individual. Interestingly, the parliamentarians make reference to a specific individual known throughout Tonga to travel when his mental condition sufficiently deteriorates, to travel from Ha'apai to Tongatapu and behave erratically.[20]

The result of these efforts, the MHA 2001, defined "mental disorder" as a "clinical condition in which a person manifests abnormal behaviour that does not meet the criteria for mental illness in this Act but the person is dangerous to himself or to others".[21] "Mental illness" is in turn defined as:[22]

> [A] condition which seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterized by the presence of at least one of the following symptoms: delusions; hallucinations; serious disorder of the content or form of thought; or of mood; or sustained or repeated irrational behaviour which indicates the presence of at least one of those behaviours.

These new legal definitions have thus had about 15 years of application yet surprisingly few cases have emerged in the mental health space. A brief

18 Government of Tonga 2003, *Record of Parliamentary Debate on Mental Health Act 2001*,and Nuku'alofa: Parliament of Tonga.

19 Ibid.

20 See also Poltorak, 2002, above n 4.

21 Mental Health Act [Tonga], 2001, s. 3.

22 Section 3.

consideration of how the state of a rights-based mental health legal praxis emerged is in order to properly contextualize Tonga's current law in this area.

III. Overview of the International Human Rights Context and Mental Health

The backdrop of what would become the MHA 2001 had some of its strongest origins in international law. A trio of international human rights documents referred to collectively as the International Bill of Rights (IBR) are the foundation of rights-based approaches to modern mental health laws. The IBR consists of the Universal Declaration of Human Rights 1948, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). From here, international bodies entrusted to review and interpret these documents from time to time issued what are known as general comments on the interpretation of a particular provision contained within an underlying treaty, declaration or recommendation. In 1996, for instance, the International Committee on Economic Social and Cultural Rights adopted General Comment 5 detailing the applicability of the ICESCR to people with mental and physical disabilities.

Application of general principles to specific situations, however, leaves room for disagreement as to the particular application of a right to a specific context. Individuals with disabilities, for instance, often have much more specific needs than do members of the community as a whole. Individuals with disabilities often suffer social isolation due to social stigma as well as institutional barriers. As such, general rights to dignity or liberty require specific elaboration if they are to have particular meaning to this population. Hence, general human rights discourses began to take a 'disability turn' during the 1970s.

A. The Disability Thematic Shift in Key International Human Rights Texts

The United Nations (UN) and associated international organisations had historically driven international policy surrounding persons with disabilities, specifically those pertaining to the rights of these persons. The turning point in this evolution of attitudes occurred in the late 1960s with a new concept of disability emerging out of the disability community discourses that focused on the connection between social context and attitudes and the prejudicial experiences of individuals with disabilities. This growing line of policy statements began with the Declaration on the Rights of Disabled Persons 1975 (discussed below), and the resulting International Year of Disabled Persons in 1981. From the latter developed the World Programme of Action concerning

Disabled Persons, which was adopted by the UN General Assembly in 1982. The UN Decade of Disabled Persons (1983-1992), which yielded an expert-vetted World Programme of Action concerning Disabled Persons at the Mid-Point of the United Nations Decade of Disabled Persons in 1987, followed these earlier international initiatives.[23]

The 1975 Declaration on the Rights of Disabled Persons[24], defines a "disabled person" in reference to the individual's ability to secure the requirements of both individual and social life that could be due to either a physical or mental incapacity.[25] This Declaration further established the right for persons with disabilities to have access to legal assistance where required, including that court procedures should take into account an individual's disability and accommodate him or her accordingly.[26] Moreover, the Declaration is one of the first internationally recognised embodiments of the inclusion not only of individuals with disabilities but also of organisations of disabled persons into the policymaking process.

In 1993, the UN General Assembly adopted the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (SREOPD). Amongst its findings, the SREOPD noted that persons with disabilities endured "[i]gnorance, neglect, superstition and fear" that have "isolated persons with disabilities and delayed their development" and that the SREOPD resulted from intellectual and policy developments surrounding disability occurring over the past 200 years.[27] States were encouraged to advance positive portrayals of individuals with disabilities in mass media campaigns and produce inclusive policy regimes.[28] This measure consists of a total of 22 provisions plus a monitoring mechanism to check on compliance established to affirm the ability of individuals with disabilities to participate in their respective societies, including fully exercising their rights on an equal basis.[29] Together, these Rules symbolise an emerging international consensus

23 The World Programme of Action presented a unifying orientation for subsequent disability policy. In 1993 the *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* were developed. Again, while not binding, these "rules" attempt to set forth a principled set of ideals designed to ensure the exercise of equal rights by individuals with disabilities throughout the world. The *Rules* harkened back to principles embodied in the International Bill of Human Rights 1948 (IBHR). The IBHR includes: the Universal Declaration of Human Rights, the ICESCR and the ICCPR, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women, as well as the World Programme of Action concerning Disabled Persons.

24 This Declaration followed the Economic and Social Council Resolution 1921 concerning rehabilitation of disabled persons as well as the Declaration on the Rights of Mentally Retarded Persons (1971).

25 DRDP [1975] s. 1.

26 Section 11.

27 United Nations, Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (SREOPD) (1993), Introduction, s 3.

28 SREOPD, s 1, s 3.

29 See SREOPD Rule 20 and s IV.

of proper and just treatment of individuals with disabilities, including mental illness.[30]

Even a cursory review of the initiatives leading up to the U.N. General Assembly's landmark *Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care* (*MI Principles*)[31] in 1991, discussed below, demonstrates the overall thrust of these measures was to address the needs of individuals with physical disabilities and to remove barriers to full community inclusion. But with the adoption of the *MI Principles*, the separate category of disability related to mental illness was set forth on its own independent path of recognition, which was followed by specific endeavours by WHO beginning in 2001.

B. *Establishing Mental Health as Human Right: The International Context*

The *MI Principles* represent the first unified effort in the specifically mental health disability context. While the *MI Principles* do not define mental illness, they define "mental health care" to include "analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness."[32] Principle 1 states that all persons have the right

30 While not completed until several years following Tonga's mental health law revision, a more comprehensive disability convention came into force in 2008 entitled the Convention on the Rights of Persons with Disabilities and an Optional Protocol (CRPD/CRPD-OP). This Convention recognised the continuing need for persons with disabilities to be guaranteed their full enjoyment without discrimination, in particular the acute needs of women and girls, children, those in poverty, minority populations or religions. In order to secure non-discrimination of those with disabilities, states signing on to this Convention are expected, amongst other responsibilities, to:

> [A]dopt all appropriate legislative, administrative and other measures for the implementation of … rights … [and] to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities...

Further, community inclusion is a central right of the broad-based disability rights movement and this Convention demands states implement laws and policies and engender practices designed to achieve fuller participation in the civic and work environments in each nation by offering support services to individuals requiring them. Tonga signed the Convention in 2007.

The Convention, again following the precedent established in WHO's regional structure, sets forth the principle of a "Regional integration organisation" which is "an organisation constituted by sovereign States of a given region, to which its member States have transferred competence in respect of matters governed by this Convention". Tonga is one of the 144 treaty signatories. These conventions and other official documents of the international community have created the institutional structure within which IOs operate and serve as the pathways along which these actors seek to transfer the norms, policies and laws from the global to local levels.

31 UN A/RES/46/119.

32 United Nations (UN), Principles for the Protection of Persons with Mental Illness & Improvement of Mental Health Care (the MI Principles) (1991, 1).

to "the best available mental health care, which shall be part of the health and social care system".[33] Also, as in the general disability measures, the *MI Principles* reinforce the due process of law protections for persons with mental illness in cases where there is an allegation of loss of legal capacity, including involuntary hospital admission. In such cases, the individual must be entitled to free legal representation. In the case of an involuntary hospitalisation, the law must reflect that the individual is subject to the hospitalisation because of a mental illness that results in serious likelihood of immediate or imminent harm to any person or because the person's judgment is limited by the mental illness to the point that the failure to retain the individual would be "likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment".[34]

The *MI Principles* begin with the premise that where the state confronts a person with mental illness and wishes to detain the individual, the person is protected by human rights protections that require adherence to natural justice principles. These principles are balanced against the state power to protect the individual from him or herself as well as to protect the public at large. If the person at the centre of such a process does not (or is unable to) give consent to treatment, then he or she has right to counsel, that informed consent to treatment must be sought in the first instance, the person is entitled to an independent review of the merits of the case and any determination to detain the individual is subject to judicial review. Ultimately, involuntary admission to hospital is warranted only if necessary to prevent harm and to care and treat the individual in question.

Identifying and treating an individual's mental illness is to be done with a careful focus on maintaining his or her personal autonomy. Any determination that a person has a mental illness must be consistent with internationally accepted medical standards. Any subsequent treatment must be suited to the "patient's" cultural background in the least restrictive environment and with the least restrictive means necessary for both the patient and for the protection of the community. Prescribed treatment must be discussed and embody an individual plan and be subject to revision. To that end, the focus should be on voluntary treatment; involuntary treatment should only be undertaken with due process of law. The *MI Principles* discourage the use of restraint or involuntary seclusion except where it is done to prevent immediate or imminent harm. Psychosurgery is never to be carried out in the absence of the patient's informed consent and sterilisation is never to be performed.

On the face of it, the *MI Principles* would seem to establish a clear framework for domestic law; indeed it was their very intention to do so. As Sylvia Bell and Warren Brookbanks argue, however, that since the human rights perspective advances a construction of the individual privileging person over diagnosis, the notion of normalising domestic mental health

33 UN, above n 27, Principle 2.
34 Principle 16.

law around the *MI Principles* can be problematic since any definition in a health context that refers to individuals as "patients" as the *MI Principles* does, is inherently suspect.[35] Related to this, the *MI Principles* did not offer a definition of either mental illness or mental disorder. The guidelines require that no determination of mental illness be made on the basis of political, economic, or social status or membership of a cultural, racial, or religious group; or from any family or professional conflict or non-conformity with moral, social, cultural, or political values or religious beliefs prevailing in a person's community. Moreover, these provisions provide that a diagnosis shall also not be made on the grounds of past treatment or hospitalisation; nor shall any person or authority classify a person as having a mental illness except for persons directly related to such diagnoses. Even then, this shall not happen unless the determination is consistent with internationally accepted medical standards.[36]

These limitations imply that, notwithstanding those behaviours that the community finds deviant or bizarre, the individual must manifest a mental illness as the primary basis for any proposed confinement and must additionally pose either a risk of harm to him or herself or others. The international mental health law context at the time of Tonga's Mental Health Act was therefore a rich and highly developed bundle of principles and concrete implementing tools that were readily available to both international consultants and Tongan policy advocates and lawyers. Principles such as access to and accommodations in administrative and judicial proceedings for individuals with diminished capacity had been in the international policy domain since at least 1975.

The *MI Principles*, adopted a decade prior to Tonga's Mental Health Act, clearly set forth guiding principles for international best practice in the area of mental health law. Principles such as the protection of individual liberty through an affirmation of natural justice rights to fair process and legal representation wherever an individual faces involuntary hospitalization or forced psychiatric treatment. Moreover, protecting individual autonomy through individualised care and treatment plans is required under these principles. Despite this clear guidance, implementation problems are apparent, particularly in how to define "mental illness" or the failure to use person-first language. We shall now discuss Tonga's law within its temporal context.

35 S Bell and W Brookbanks Mental health law in New Zealand (2005, New Zealand, Thomson Reuters).

36 For state law examples see Mental Health Act 1983, s 13 (UK) and the Mental Health Compulsory Treatment and Assessment Act of 1992, s 4 (NZ). See also Bell and Brookbanks, above n 35.

IV. Tonga's Mental Health Context and Law in Historical Perspective

This section shall first present a brief discussion of Tonga's current mental health apparatus as situated within the overall health sector. Following this discussion, some of the key indicators of Tonga's mental health profile from an international perspective will be considered before turning to the main discussion of Tonga's history of law and policy transfer in the area of mental health with particular attention to a review of Tonga's own policy history of mental health as public issue. The final portion of this section shall consider two recent mental health decisions in Tonga and their place within the Tongan mental health policy context.

A. Evolution of Tonga's Mental Health Law

As introduced above, Tonga's legislative history on mental health began with the Lunatics Detention Act of 1948. This remained as the nation's sole mental health law until 1992 when the first Mental Health Act was adopted. As noted above, while ostensibly modernising the terminology used in the law, this act also included treatment of those with substance abuse issues within its scope.[37] The current act, the Mental Health Act 2000, was passed by parliament as part of general health sector reform undertaken at the time.[38] These reforms involved significant collaboration with key multilateral and bilateral development actors, including the Government of Australia, which supported a comprehensive sector assessment to guide the law reform process.

Once the initial assessment was completed, a formal Memorandum of Understanding was signed between the Government of Tonga and the Government of Australia setting forth the Tonga Health Sector Management and Planning Project with the overall goal "to significantly improve the planning, management and delivery of health services of the Government of Tonga".[39] The project would be done in three phases. Phase I took place between February 1999 and February 2001 and involved "intensive diagnosis of capacity".[40] Phase II was designed to build on the Phase 1 diagnostics and Phase III – from September 2003 to August 2004 – focused on sustainability and coordination of achievements from the earlier phases as well as developing a model and guidelines that other government agencies could use. Phase III was extended and a completion phase was added focusing on sustainability. The project adopted a collaborative approach with close links between the project team and ministry staff. At the same time, cooperation parameters as well as stakeholder roles were clearly defined. This framework was intended

37 Mental Health Act 9 [MHA] 1992, s 2 [Tonga].

38 Government of Tonga, *Record of Parliamentary Debate on Mental Health Act 2001* (2003).

39 Government of Australia and Government of Tonga, *Memorandum of Understanding on Health Sector Reform Initiative* (1999).

40 Ibid.

to enable "ministry staff to propose, negotiate, and ultimately define the key directions and focus of the project themselves".[41] The project involved highly interactive meetings, consultations and discussions and was referred to as a process of "developing Tongan solutions to Tongan problems".[42] The reform process was lead by Hon. Viliami Ta'u Tangi, a surgeon appointed Minster of Health in March 1999.

The relatively recent creation of the regional Pacific Islands Mental Health Network (PIMHnet) has been critical in mental health law and policy proliferation and coordination. PIMHnet, echoing the words of other NGOs active in Tonga, lamented the scarcity of funding for mental health issues given the predominance of NCD funding in the health field.[43] Similarly, the organisation mentioned the focal shift in international funders, particularly in New Zealand where the organisation is based, away from "poverty" as the main development theme to that of "sustainable development".[44] A PIMHnet official noted unique circumstances in Tonga contributing to the failure to adopt a mental health policy to accompany the Mental Health Act including the absence of a focal person for mental health during key periods of policy reform as well as dealing both with a tsunami and a ferry disaster.[45] From the Tongan perspective, however, the absence of a national focal contact was seen merely as a scheduling difficulty of short duration that could have easily been remedied. But the absence of a central highly placed political insider during a key policy change moment would seem to be a significant factor in Tonga's failure to adopt a mental health policy. At the same time, the insistence on a local focal person for statutory development does not seem to have been a high priority. While local individuals reported being talked to by the foreign consultant about the law development in its embryonic development, drafting and editing until translation into Tongan seems to have been a predominantly foreign occupation.

In addition to PIMHnet's involvement, WHO contributed significantly to these reforms by providing a consultant to draft the new law. Yet, within the overall health sector reforms then sought, mental health was not considered a priority. As one international organization respondent felt that in regards to mental health in Tonga:[46]

> … I'd say it's not at all a major priority, I'd say it's probably an issue, probably a difficult issue as in a small country where you've got someone with mental illness it's a shame to a family, something people talk about, Tonga being a small

41 Government of Australia and Government of Tonga, *Declaration on Aid Effectiveness between the Government of Tonga and Development Partners* (2007).

42 Government of Australia and Government of Tonga, above n39.

43 Interview with the Author (Wellington, May 2011).

44 Ibid.

45 Ibid.

46 Interview with Author (Nuku'alofa, February 2011).

> country, everyone knows what's going on. There's not a lot of open advocacy on mental health, as far as I can see, it's been kept relatively quiet.

This connected with the overall sense that NCDs remained the top health priority in Tonga and there was little association of the persisting mental health burden with the increasing NCD burden. The sense was that mental health was neither being vigorously pursued by the Ministry of Health nor insisted upon by Geneva as a matter requiring sustained attention. As such, while the legislative reforms have occurred, the implementation of other aspects of mental health system development, such as community education to increase understanding of the complexities of mental ill health and wellness as part of a stigma-reduction (and human rights protection platform) has failed to materialise.

As noted above, mental health matters are typically handled in the family and community in the first instance; a quite common phenomenon throughout the world. In Tonga, however, the 'community' dimension refers primarily to the importance of traditional healers in initial mental health treatment. Traditional remedies centre on massage and other calming salves and ointments in an effort to address a spiritual disruption leading to the symptoms experienced. After the home and community attempts, the next step for individuals with a mental illness in Tonga is within Tonga's mental health system, which essentially orbits around the nation's sole psychiatrist, a Tongan, Dr Mapa Puloka. Dr Puloka oversees the national mental health unit and small staff located at the nation's main hospital in Nuku'alofa. As in other jurisdictions, other common state actors often implicated in mental health symptom management include the prosecutors, courts and prison system.

Tonga's legislative changes in the area of mental health occurred within the health sector reforms in 2001, culminating in the MHA 2001. AusAID had been enlisted to assist (in both dollars and expertise) with the overall health sector reforms involving management and human resource reforms as well as registration provisions for doctors and pharmacists. Tonga was provided an Australian legal consultant via WHO to provide the legal drafting for the respective Acts. Local officials or experts aided the drafts. One respondent reported that the Australian consultant:[47]

> … was a specialist in health legislation and mental health, she came and we did a lot of talking. She came many times; she came for mental health and came for the others [proposed

47 Interview with author (Nuku'alofa, February 2011).

> health legislation] as well. But she consulted me a lot of time … […]
>
> So we were involved in the sharing of information with [the consultant] and I understand that although she drafted the law, it was based largely on an existing law form Australia […] You understand that in the past here in Tonga, other Ministries, as no one is the expert, they often followed laws from New Zealand or some place and just change some details and make it the official document for Tonga. That has been the common practice. Now there is a greater desire to inform the public now when making an official document.

The WHO, even though working as part of these overarching AusAID supported health sector reforms, provided this consultant. In addition, respondents suggested that the consultant's initial draft underwent considerable editing by the then Chief Judge in Tonga, a British jurist who had worked in Tonga and other islands for many years.[48]

Table 1 below provides a summary of the key themes identified through analysis of Tonga's MHA 2001. Of course, legislative changes often given rise to legal disputes and questions of interpretation. Tongan law has had few cases considering questions of involuntary confinement under any of its several iterations of law in this area. Two recent decisions have raised issues under the MHA 2001 and will be considered in the next section together wish consideration of the role of natural justice in Tonga and its potential as a vehicle for rights-based questions implicating the MHA 2001.

B. *Natural Justice, Mental Health and* R v Manu *and* Re Application by Kama

The contemporary concept of natural justice in most common law countries is often traced to Lord Esher's pronouncement that it was essentially "the natural sense of what is right and wrong".[49] Tongan jurisprudence has tended to apply natural justice principles to questions of process rights in termination of the employment relationship.[50] The clearest pronouncement of natural justice principles as understood in Tonga came in the 1999 case of *Tu'ipeatau v Kingdom of Tonga*.[51] Justice Finnigan found that in Tonga, the principles

48 Interview with author, above n 49. In fact, one respondent suggested that perhaps 40 per cent of the original draft was cut by the then Chief Justice and other members of the Law Reform Committee, though there was no way to independently verify this impression.

49 *Voinet v Barrett* (1885) 55 LJQB 39 at 41.

50 See, for example, *'Asitomani v Superintendent of Prison* [2003] Tonga LR 84; Tu'ipeatau v Kingdom of Tonga [1999] TOSC 50; C 1031 1995; Leiola Group Ltd v Moengangongo [2010] Tonga LR 85 (14 July 2010).

51 *Tu'ipeatau v Kingdom of Tonga* [1999] TOSC 50; C 1031 1995 (application dismissed).

of natural justice are met where (1) the decision-maker is disinterested and unbiased; (2) where adequate notice of the proceedings with an opportunity to appear and present evidence is afforded the interested party the person; (3) the decision-maker has genuinely considered any explanation given; and (4) the decision-maker gives reasons for the decision.

In reaching his decision that Tu'ipeatau did not establish a violation of these principles, Justice Finnigan quoted Lord Donaldson's language from *Lloyd v McMahon*[52] thusly:[53]

> My Lords, the so-called rules of natural justice are not engraved on tablets of stone. To use the phrase which better expresses the underlying concept, what the requirements of fairness demand when any body, domestic, administrative or judicial, has to make a decision which will affect the rights of individuals depends on the character of the decision-making body, the kind of decision it has to make and the statutory or other framework in which it operates. In particular, it is well established that when a statute has conferred on any body the power to make decisions affecting individuals, the courts will not only require the procedure prescribed by the statute to be followed, but will readily imply so much and no more to be introduced by way of additional procedural safeguards as will ensure the attainment of fairness.

This guidance, as applied *Tu'ipeatau*, led to a conclusion that natural justice as fundamental procedural fairness had not been violated. Yet, the decision is an important one for it established the principle that such determinations are for a court to reach in individual cases based on individual circumstances.

At the same time, the fundamental question of deprivation of a private right by a public entity is one ripe for extension into other areas of law not least of which might be to alleged arbitrary state action in the area of individual rights and the exercise of liberty for individuals facing involuntary commitment in the national psychiatric unit. In Tonga, significant questions arise under such principles in the case of involuntary confinements under the MHA 2001. It is true that the MHA 2001 provides for a Mental Health Tribunal[54] that ordinarily is to consist of three parties, a magistrate with a law degree, the national psychiatrist or other medical practitioner with "experience in psychiatric medicine" and a lay member having "other relevant skills or experience".[55] Yet, the quorum is two of the three members and in some cases

52 *Lloyd v McMahon* [1987] 1 All ER 1118.

53 *Tu'ipeatau v Kingdom of Tonga* [1999] TOSC 50; C 1031 1995 citing Lloyd v McMahon [1987] 1 All ER 1118 at 1161.

54 MHA 2001, Part XIII.

55 Section 128.

only one member need be present to confine someone in the psychiatric unit against their will for an indefinite term.

This Part also contemplates decisions reached without the presence of the individual facing commitment so long as they have been given notice and opportunity to attend.[56] Although it is puzzling to consider how this might apply to a situation where the individual is most likely already in custody or where the government is offering that the individual is burdened under a mental condition so severe as to require forced confinement and treatment. In sum, while appeals may be taken for alleged errors under the MHA 2001, it is clear that in addition, the Act itself or decisions reached under any of these provisions, might also be attacked as failing to meet some of the mandates of natural justice. Failing to do so, particularly where a decision has been reached without the appearance of the individual proposed for admission as an involuntary patient, raises substantial natural justice concerns and might warrant a re-hearing on the evidence supporting the involuntary admission order.

The courts have considered this law in at least two contexts since its adoption, those cases involving criminals who are found to be either mentally ill or disordered following evaluation and those cases were someone is subject to involuntary civil commitment. In *R v Manu*[57], the trial judge imposed a sentence that included both a lengthy prison term (23 years) and under section 67(1) MHA 2001 [Tonga] ordered that a "treatment order" shall remain in force over Mr Manu for the "rest of (his) natural life".[58] Despite the fact that the imposition of a life-long treatment order has been made part of a criminal sentence, the order itself does not envisage the cessation of Manu's treatment or a regular schedule for judicial review of such orders. These both raise significant natural justice concerns for Manu since such an order is apparently justifiable under the MHA 2001. Advocacy for Manu could focus on an appeal to such process rights in order to at the very least, ensure that any treatment plans developed for him are reasonable and involve the least restrictive or intrusive means of delivering the prescribed treatment. In addition, review on these grounds would ensure that whatever treatment plan developed for Manu is subject to regular review and revision based on his individual needs. This case did not directly address the distinction between a "mental illness" and a "mental disorder" under Tongan law a question later taken up by the Supreme Court in *Kama*.

The second area of interpretation considered was procedurally brought as a *habeas corpus* action but ultimately involved interpretation of the Mental Health Act. In *Re Application by Kama*[59], the Supreme Court was asked to consider whether one was classified as having a mental disorder or mental

56 Section 134.
57 R v Manu, CR Case 127-2002 (Tonga).
58 At 16.
59 Re Application by Kama, [2007] Tonga Law Rp 12.

illness under the Act made a substantive difference in terms of detention and whether detentions at Huatolitoli prison was lawful.

The Court rejected the application for *habeas corpus* finding that while there was indeed an error in the committal order finding Kama was suffering from a mental disorder and instead the evidence demonstrated he was in fact suffering from a mental illness. The Supreme Court found that while the Mental Health Review Tribunal (the entity empowered under the MHA 2001 to make initial determinations on civil commitment matters) used the term "mental disorder" in its orders, the underlying medical certificates were based upon findings of a "mental illness" and further that there were findings of his "dangerousness" at this time warranting his detention instead of community treatment.

The second issue the Court considered was whether, under certain circumstances, an individual could be detained for treatment at Huatolitoli prison. Again, the court ruled in the affirmative. Under a Privy Council order in 1993, the dedicated portion of the prison for the treatment of individuals with mental illness or disorder was deemed a "hospital" under the MHA 1992. This unit is used for both forensic patients as well as those subject to inpatient or community treatment orders who cannot be effectively treated in the mental health unit. The Court found that section 143 of the MHA 2001 preserved the Privy Council designation of the prison facility as hospital while repealing the MHA 1992. Therefore, the writ was denied and Kama's detention was deemed lawful.

Here the court engaged in a *de novo* review of the underlying evidence of mental health diagnosis considered by the Mental Health Tribunal and determined that mental disorder and mental illness are essentially one in the same, the new statutory language had changed nothing but the terminology used in reaching a determination to confine and treat an individual. Perhaps of more concern to advocates is that despite the presence of a secure mental health facility at the national hospital, the Privy Council's designation of the national prison as a "mental health facility" was found to endure. Given this, it is difficult to see how either the process or outcome changed under the 2001 Act from the 1992 Act. What was not raised in these cases was the application of natural justice principles to the mental health adjudications process.

V. Discussion

Given that Tonga's law was drafted in 2000 by an international consultant working with the Government of Tonga through an international organization and that Australian law was identified in interviews as the basis for Tonga's Mental Health Act, this study compared the texts of the *MI Principles* and two of Australia's key mental health legislations: South Australia's Mental Health Act (1993) and Victoria's Mental Health Act (1986). These texts

were analysed to identify the frequency of key terms within the texts and to compare the select texts. Both Acts refer to a "person" and "patient" in terms of the affected class of individuals. "Treatment" is a similarly frequent focus of both Acts. Victoria's makes more specific reference to "hospital", "medical", "psychiatrist", "patient" and involuntary admissions. South Australia's Act refers more broadly to "practitioner" indicating a broadening of the class of individuals competent to make preliminary mental health custody determinations. Neither Act refers to "disorder" or "illness" with any prominence. The definitions adopted here are more nuanced and explicit than the 1992 Act.

Table 1: Key Themes of Tonga's Mental Health Act (2001) (weighted percentage)

Who is subject to law?	What is assessed and by whom?	What process is followed?	What services are envisioned?	Where does treatment occur?	Are other rights identified?
Person (4.07) Patient (1.13)	Authorised (1.36) Psychiatrist (1.13) (medical) (0.71) Practitioner (0.57) (illness) (0.53), Criteria (0.43)	Order (1.60) Review (0.95) Court (0.48) Grounds (0.41) Committee (0.36) Visitor (0.35) Assessment (0.33)	Treatment (1.84) Care (0.95)	Facility (1.29) Admission (1.28) Involuntary (1.12) Community (1.11) Forensic (0.36)	Consent (0.47) Informed (0.28)

Similarly, the specific separate categories for drug and alcohol addictions were removed. The law, however, failed to incorporate many of the formal rights protections found in both Australian law as well as those of the *MI Principles*.[60] For instance, one of the identified source laws for Tonga's Act was the Victorian Mental Health 1986, which made explicit policy exclusions from the definition of mental illness for conditions such as acting immorally, for promiscuity, failing to promote or exhibit preferred political beliefs, or the consumption of drugs or alcohol. These provisions are clearly excluded diagnostic criteria in both the Victorian law as well as the *MI Principles* yet are conspicuously absent in the 2001 Tongan Mental Health Act. It seems

60 UN, above n 27.

unlikely that a consultant brought in by WHO would purposely exclude these provisions. Instead it is far more likely the Law Reform Committee removed the provisions.[61] Further, as discussed above, the *MI Principles* indicate that involuntary confinement in a hospital is appropriate only in order to prevent harm while providing treatment. And that treatment must be provided consistent with an individual treatment plan subject to revision. Finally, the *MI Principles* contain specific prohibitions that "mental illness" not be used as a label enabling state confinement of those exhibiting undesirable social, political or cultural traits.

Tonga's law embodies an older generation of mental health law. Notably, Tonga's law does not contain general exclusion provisions for certain behaviours common in liberal democracies such as voicing an opinion contrary to a dominant political party, as found in other regional Mental Health Acts. In addition, Tonga's mental health law makes specific reference to the position of "psychiatrist" and his (or her) function in "involuntary" admission to a "facility" for individuals with a mental illness, who then are labelled "patients" under the Act. This language, on balance, reflects more closely Victoria's Mental Health Act dating to 1986.

The *MI Principles*, adopted in 1991, do not seem to be significantly reflected in Tonga's law. The Act, however, contains substantial process protections as advanced in the *MI Principles*. Tonga's Act contains provision for a Mental Health Tribunal to review admissions determinations, while maintaining judicial review of civil commitments, a Mental Health Advisory Committee, consisting of community members, individuals with mental illness and their families, and other key mental health actors. This Committee is designed to advise the Minister of Health on matters pertaining to the mental health system. Finally, the law also continues the institution of "visitor". A visitor is an independent community watchdog with the power to inspect the mental health facilities. Each of these institutions is intended to balance the individual and community concerns against determinations made by the designated health practitioners.

While these mental health laws were almost entirely based upon two Australian state laws (Victoria and South Australia) they nonetheless constituted a significant reform of the then existing statutory framework. At the same time, however, within a few years of these enactments both Australian source laws underwent significant community review and revision. For example, a review of the 1986 Victoria Mental Health Act (MHA) was launched in May 2008, little over five after Tonga's Act was ultimately enacted. Stating the need for review, the State Government of Victoria revealed that:[62]

61 Unfortunately, the dearth of available commentary on the legislative process as well as the unavailability of key participants in this reform process during this research leaves any definite answer to this question speculative.

62 State Government of Victoria, *Review of the MHA* (2010, v). Notably, this law was only ultimately replaced in 2014.

> *The MHA is the oldest mental health law in Australia* and it has not been comprehensively reviewed since the mid-1990's. Apart from modernizing the MHA, the review aimed to make the MHA more consistent with the *Victorian Charter of Human Rights and Responsibilities* and the *International Convention of Persons with Disabilities* (emphasis added).

Given this, Tonga's reformed law did not fully reflect the latest international mental health best practices as embodied in the *MI Principles* or other international sources. In addition to building and perpetuating a dependence on foreign expertise in this area, the transferred laws continue to fall short of the most current position of the policy area. For instance, the MHA overhaul was motivated by a presumption that individuals with mental disorder should be supported in making independent decisions and only where a determination has been made to the contrary should the state be involved in individual autonomy. This principle is consistently embodied in provisions such as in formally recognising advance statements by individuals when they had legal capacity about their wishes should that capacity cease for any reason, including directing care options.

At the same time, it is clear that the 2001 Act fails to capture indigenous mental health values or constructions of mental health from a Tongan perspective. Instead, the law reflects what is missing from the Tonga's mental health system: gone are the requirements for independent decision making and there are no accompanying protections for Tongan families to be full participants in the mental health adjudications or treatment planning process. In short, Australian law was borrowed with cuts made to this template - the omissions constitute the Tongan context - definition by omission. While convenient and undoubtedly insulates the law from attack on the basis that it embodies unenforceable or inapplicable legal mechanisms, the law also comes to offer fewer and fewer protections for individuals with mental illness as found in the international instruments discussed in this article.

In sum, the extensive international texts supporting a rights-based mental health system for the world were instrumental in moving the issue of mental health onto the international policy agenda but were not found to significantly inform Tonga's law. Further, when policy actors crafted a legal framework for Tonga and required source material to guide them, they tended not to rely on these international resources. Instead, the evidence presented here suggests that the foreign legal practitioners utilised domestic laws with which they were intimately familiar from their home jurisdictions.

For instance, and as evidence of this, the South Australia Mental Health Act adopted in 2009 included provisions to work collaboratively with traditional healers. This inclusive theme within primary care settings was both common in the international mental health development literature and Tongan respondents observed the presence of (and at least initial preference for) traditional healers in the indigenous mental health system. This language,

however, was not included in Tonga's Mental Health Act. It is fair to note that these proposed changes were not part of the relied-upon Australian legal frameworks at the time either, but they were not novel concepts. The ICRPD, for instance, has been widely used by mental health advocates throughout the world for many years.

Statements of Rights in older laws tended to provide only the requirement that natural justice principles be communicated to the individual and observed by courts and tribunals. Newer versions of both Australian state laws include "Guiding Principles" and "Objectives" sections, formerly found only in policy statements. Most notably, the new laws build on the least restrictive environment requirement of second-generation mental health laws and seek to include family and carers in the circle of treatment regimes. This is notably absent in Tonga's Mental Health Act given that both indigenous and international actors alike repeatedly cite family as a key strength of Tonga's system.

Finally, it is of note that the only published opinions arising under the MHA 2001 have addressed ostensibly natural justice principles. Moreover, the legality of a treatment order entered for the remainder of one's natural life is indeed questionable from the standpoint of the *MI Principles* and on natural justice grounds but it is unclear whether that portion of Manu's sentence has been challenged. Presumably, given the wide powers of the treatment order provision, Manu's sentence could effectively be a life of imprisonment. There is precedent for such indefinite detentions. Whether such detentions would be found constitutional in Tonga are uncertain and these serious questions remain yet to be determined. It also remains to be seen whether decisions to detain individuals under the MHA for deviant behaviour that would otherwise have been proscribed by the latest generation of mental health laws informed by the *MI Principles*, such as neighbouring Samoa's Mental Health Act (2007), can be challenged under Tonga's constitution.

In addition, without explicit prohibitions on the use of such confinement powers on the basis of unpopular political, social or cultural attributes, only constitutional and natural justice principles are currently available to individuals wanting to challenge their detention. As seen in *Kama*, even when the wrong statutory category serves as the basis for an inpatient treatment order where confinement in the national prison is ordered, such claims are the primary vehicle with which to challenge one's detention.

VI. Conclusion

Contemporary mental health principles, such as respect and dignity for the individual, reducing stigma associated with a mental illness, and community treatment have been subjects of both local and informal initiatives. In fact, these efforts had been underway before mental health had been prioritised on the international level. The formalisation of these

principles, however, involved the presence of local professional-experts to 'contextualise' the international renditions of 'best practice' into the local. Tonga's legal framework, in contrast, did not necessitate local professional experts but required the availability of international experts to provide the necessary official 'confidence' in the proposed reforms necessary to see their adoption.

Tonga's legal framework, in contrast, has long been inextricably linked to the legal practitioners and jurists, many of whom were British, Australian and New Zealand expatriates; the local practitioners and judges were all trained in one of these three nation's law schools. In other words, there has been low connectivity between these laws and the community because they were hardly ever utilised or encountered by large numbers of people beyond the bench and bar and the medical professionals whose evidence was necessary to issue confinement orders. In fact, Tonga's sole psychiatrist reiterated one of his priorities in the recent Mental Health Act was to further restrict the type of legal practitioner capable of working on mental health as one holding a law degree and not a local practitioner who had become qualified through apprenticeship. This step, whilst assuring a degree of professional intimacy with the law and legal thinking, serves to further entrench mental health determinations within the narrow confines of a technical, legal determination made by 'experts'.

An important lesson offered by these reforms is the importance of practical application of borrowed laws, introduced as part of a law transfer process. In Tonga, it was vital that the transferred law fit within existing institutional structures and be accessible by practitioners and jurists alike. These actors were, on the whole, educated and trained in British-derived legal systems. The presence of British and Australian legal actors in the law adoption process suggests that the functional utility of the law was vital to the form the law ultimately took. While documents such as the *MI Principles* might provide important guiding principles for mental health law, they remained just that in the process, principles. The far more important textual sources were found to be laws serving similar functional purposes in the country from which the primary legal consultant came. Yet, at the same time, practitioners and representatives of civil society in Tonga were for the most part satisfied with the Act. The omission of important enumerated human rights protections seemed to matter very little to these actors. These actors shared a common confidence in the functioning of the mental health system and in its respect for natural justice rights if not in the more expansive rights-based protections found in regional laws adopted in the Pacific in the years since Tonga's law began the recent trend of mental health law reform. Finally, as demonstrated in this article, given the need for foreign involvement to bring about mental health legislative changes, the adoption of a law based upon something less than the then prevailing best practices in terms of rights-based mental health laws, no matter how functional the law proves to be, continues the long-standing problem of sustainability of indigenous law reform processes in Tonga.